LOS ANGELES COUNTY COMMISSION ON HIV

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COMMISSION ON HIV MEETING MINUTES
October 11, 2007

Approved 12/13/2007

MEMBERS PRESENT	MEMBERS ABSENT	PUBLIC (CONT.)	OAPP/HIV EPI STAFF
Carla Bailey, *Co-Chair*	Ruben Acosta	Ted Liso	Chi-Wai Au
Anthony Braswell, *Co-Chair*	Alicia Crews-Rhoden	Luis Lopez	Kyle Baker
Al Ballesteros	Whitney Engeran	Richard Martinez	Angela Boger
Diana Baumbauer	William Fuentes	Richard Mathias	Maxine Franklin
Anthony Bongiorno	David Giugni	Stacy Mungo	Michael Green
Carrie Broadus	Jan King	Manuel Negrete	Rita Jones-Raz
Mario Chavez	Elizabeth Mendia	Jose Paredes	Mary Orticke
Eric Daar	Gloria Pérez/Terry Goddard	Elye Pitts	Carlos Vega-Matos
Nettie DeAugustine	James Skinner	Jane Price	Lanet Williams
Douglas Frye	Peg Taylor	Jeff Reed	Juhua Wu
Jeffrey Goodman/Sharon Chamberlain	Jocelyn Woodard/James Smith	Daniel Rivas	
Joanne Granai		Jill Rotenberg	
Richard Hamilton		Yolanda Salinas	**COMMISSION STAFF/CONSULTANTS**
Michael Johnson	**PUBLIC**	Miki Salksun	
Lee Kochems		Rose Veniegas	Virginia Bonila
Brad Land	Arron Barba	Jane Wallace	Jane Nachazel
Anna Long	Cinderella Barrios-Cernik	Tim Young	Glenda Pinney
Ruel Nolledo	Brenda Camarena		Doris Reed
Quentin O'Brien	David Crain		James Stewart
Everardo Orozco	Phil Curtis		Craig Vincent-Jones
Dean Page	Lisa Fisher		Nicole Werner
Angélica Palmeros	Susan Forrest		
Mario Pérez	Veronika Geronimo		
Natalie Sanchez	Shawn Griffin		
Gilbert Varela	Charles Hilliard		
Chris Villa	Andres Jackson		
Kathy Watt	Carol Kim		
Fariba Younai	Gabriela Leon		

1. **REGISTRATION/WELCOME**: Mr. Braswell welcomed all participants to the Annual Meeting, calling attention to the AIDS quilt on the wall.

2. **CALL TO ORDER**: Mr. Braswell called the meeting to order at 9:10 a.m. Quorum was met.
   A. **Roll Call (Present)**: Baumbauer, Bongiorno, Bailey, Braswell, Broadus, Chavez, Daar, DeAugustine, Engeran, Frye, Goodman, Hamilton, Johnson, Land, O'Brien, Page, Palmeros, Sanchez, Watt, Younai

3. **APPROVAL OF AGENDA**:
MOTION #1: Approve the Agenda Order ***(Passed by Consensus)***.

4. **PARLIAMENTARY TRAINING**: Mr. Stewart reminded the group that only an amendment can affect the outcome of matters under consideration, not simply airing concerns.

5. **PUBLIC COMMENT, NON-AGENDIZED**: There were no comments.

6. **COMMISSION COMMENT, NON-AGENDIZED**:
   - Mr. Goodman noted he had sought dental services for an extraction and was denied services because of his "medical condition". He found it traumatic and noted that, if it happened to him, it was happening to many people with HIV. He reported that the City Attorney was pursuing the case. In addition, Orange County may initiate a class action suit against the same provider and expand it to Los Angeles County with Mr. Goodman as the named plaintiff. The provider is a large one. The situation has brought home to Mr. Goodman that the Commission's work is still needed.
   - Dr. Younai supported Mr. Goodman's action and recommended he also report the dentist to the Dental Board of California. She said they did investigate such cases.

7. **REVIEW OF ACCOMPLISHMENTS**:
   - Mr. Braswell said he had heard great feedback about the prior month's public hearing on corrections, and began reviewing the Commission's accomplishments from the past year, as outlining in the packet.
   - From the Executive Committee, he felt especially proud of completing the draft MOU, the quality of the application and the first performance appraisal by the Commission of the Executive Director.
   - Mr. Engeran felt the biggest JPP accomplishment for the year was rejoining the Commission's and PPC's Public Policy Committees. He thanked their PPC colleagues and all involved. He felt the Corrections Public Hearing was very important and would like to see more such hearings in future. He expressed pride in the work of the Ryan White Subcommittee and its efforts.
   - Dr. Younai commented that, after finishing the standards, the SOC realized it would need to address the care coordination model. The Medical Care Coordination Framework was the result of many long meetings with the SOC, the community and all the stakeholders. About half of the tasks remaining after finalizing the standards have been completed. The final sections of the standards are being completed and three guidelines for special populations have been developed. They look forward to finalizing the entire document and disseminating it. Ms. Palmeros added that the amount of community input had been wonderful.
   - Ms. DeAugustine felt the redesign of the Year 15 AAM would enhance assessments and improve their usefulness for years to come. She gave credit to Mr. O'Brien who had served as a co-chair of the Finance Committee and had initiated much of that work. She highlighted the new consumer membership and involvement plan, including interviews for new members to enhance mutual understanding and mentorship. Operations completed all the duty statements. She said that while there was a lot of work still to do, there had been key progress in assimilating work previously done by the Finance and Recruitment, Diversity and Bylaws (RD&B) Committees.
   - Mr. Goodman also indicated that P&P had to absorb some Finance Committee responsibilities. He said that, as a Ryan White transitional year, P&P worked hard to revise Year 17 in mid-cycle to be in compliance with the new Ryan White Treatment and Modernization Act. He felt the work would be valuable going forward. He also highlighted the new needs assessment process, LACHNA, in conjunction with OAPP and the PPC.
   - Mr. Braswell noted that the date of the November meeting needed to be changed. Members agreed to reschedule to Friday, November 2nd. The Executive Committee was then rescheduled to October 22nd.

8. **MEDICAL CARE COORDINATION FRAMEWORK**:
   A **Presentation of the Revised Framework: Incorporating Public Comment**:
      - Dr. Younai indicated that there were changes in formatting, organizational structure, language edits and a change in the order of the program design to provide a more logical progression and patient flow of services.
      - Changes to the process section began on page 8 with an enhanced timeline description including details on community outreach. A section on the importance of financial/caseload simulation modeling had been added in response to comments. Implementation stages were also elaborated including, for example, the modeling.
      - There were some changes to model components. A "Financial Impact" section was added prioritizing client well-being while ensuring that the model would not be cost prohibitive. The financial modeling would need to be done concurrent with standards revision.

- Continuum of Care changes maintain multiple entry points while ensuring linkage to medical care and detailing provider-to-provider outreach/communications. Patient provider choice is maintained and required by law.
- The Program Design section emphasized that services need not be co-located, but must be coordinated, including substance abuse/mental health service agreements. Service and program agreements were designated.
- Operational program thresholds were added, including staffing and minimum hours, some of which could be field hours. Coordinator was changed to Manager in order to provide a better sense of authority.
- Treatment Education, and Transitional and Home-based Case Management would be kept as separate categories. Transitional Case Management services were maintained as a bridge for special populations in transitional circumstances. Benefits Specialty would be folded into the Care Coordination model and better delineated during further standard development.
- Ms. Palmeros addressed Coordinated Care changes. Triage and assessment were merged into an intake process for a more comprehensive approach. Intake would assess acuity and assign a primary contact.
- Case conferencing requirements were changed to reflect input. While an ideal, it would not be required of every client. The agency would determine appropriate levels.
- A Client Line would not be incorporated in this mode. Instead, outreach would be included and studied to increase its effectiveness. Outreach should be conducted for non-active clients, clients lost to care and unmet need.
- Coordination among providers was addressed. The primary provider would receive reimbursement as such and would coordinate with other program(s) regarding care and reimbursement.
- Ms. Palmeros noted that there were discussions regarding integration of prevention and care. The model does incorporate counseling/testing and outreach, but not prevention case management. Standards would be reviewed to ensure continuity.
- Regarding patient acuity, Ms. Palmeros noted there would be greater elaboration in the standards. As additional special populations were identified and studied, additional guidelines would be developed.
- Ms. Palmeros said quality management and service effectiveness processes would be used to assess implementation.
- The recommendations detail additional work needed for the standards. Also, the outreach component will necessitate additional funding. Finally, financial and caseload simulation modeling was also specified.

B. Discussion:

- Mr. Engeran asked about the process. Dr. Younai said the Framework was presented to the Commission in July followed by presentations at 8 SPN meetings, 2 consumer meetings and the Case Management Task Force, the Medical Outpatient Caucus and the District 2 Coalition. All comments were considered and many were incorporated. Ms. Palmeros noted there were also additional SOC meetings discussing the issue during that time. Dr. Younai indicated that the SOC Committee would develop the new care coordination standard, along with its financial simulation, once the framework was approved.
- Ms. Broadus asked if the Framework would be considered a pilot project since there had not yet been financial modeling. Mr. Vincent-Jones said it was hard to pilot because some providers would gain an experience advantage in later procurement and there were ethical concerns in providing what would be considered better services to some clients. The Framework was designed to provide a model to be reflected in revised standards that could then be used for financial simulations. Those simulations would be completed before allocations.
- Mr. Nolledo also expressed concern about the financial impact. While the Framework was anticipated to be possibly more expensive but not cost prohibitive, there did not seem to be data for that. He also noted an ethical consideration if implementation led to inability to serve clients. Dr. Younai said chronic disease management models have been implemented and the Framework relied heavily on those models. Mr. Vincent-Jones indicated that the framework is similar to the Medi-Cal Waiver program, which has been implemented in numerous locales and venues—including LA County.
- Mr. Johnson said the basic cost of a nurse was $65,000 per year. It should be possible to estimate those program costs. Based on 120 clients per nurse, one program he knew would have costs of $350,000 for four nurses. Mr. Vincent-Jones indicated that the framework does not call for every client would have a nurse case manager, and that there were existing nurse case managers in the system.
- Ms. Broadus was concerned about a safety net for clients lost to care. It appeared the model moved from a community care to an institutional care model. Dr. Younai responded that the current system lacked a good safety net, and central care coordination services were designed, in part, to improve the safety net. Transitional case management was designed to help new people get into the proper services and ensure medical care was being accessed, and would be kept as a separate service.
- Mr. Ballesteros asked why prevention case management was not included. Mr. Vincent-Jones said the PPC had always had oversight over that service category, so SOC was in the process of developing closer coordination on the issue.

- Mr. Curtis asked if Home Health Care programs were asked about their costs as the models were similar. Mr. Vincent-Jones said several representatives attended meetings but, as the financial step was to follow, they were not asked to contribute cost information yet, but would be in the future.
- Mr. Page asked if approving the framework meant it would go to OAPP and be implemented, Mr. Vincent-Jones responded that the Commission's had designed a deliberative step-by-step process that started with the development of a framework that would lead to standards and financial simulations, and eventually allocations for those services. OAPP is in charge of implementation, but the framework also included some implementation recommendations. Mr. Engeran added that the framework was based on listed research, and multiple votes would be required before any implementation. Mr. Land felt the Commission could use directives and the P&P Committee process even in some procurement areas.
- Ms. Broadus asked what was meant by case conferencing being an indication of professionalism. Dr. Younai said there was agreement that professionals needed to determine what case conferencing was appropriate for a particular client.
- Mr. Land noted that this was a transition from an emergency care system to a managed care model. The reauthorization, however, did not provide funding for the transition it inherently mandated. His main concern was how to fund it. He felt other resources needed to be examined. Mr. Vincent-Jones replied, regardless of the model, the Commission was responsible to address the global problem of tight resources and cost-effectiveness.
- Mr. Goodman noted that he had talked with Mr. Vincent-Jones and "Medical Case Worker" on page 13 was a typo. It should be "Social Worker".
- Ms. Broadus asked if approval of the recommendations meant incorporating them into the standards. Mr. Vincent-Jones confirmed that where they pertained to the standards, those issues would be addressed in the standards development. He added that the recommendation during the meeting of incorporating "prevention case management", and any other recommendations from the day agreed to by the Commission, would be part of that.
- Mr. Johnson noted that, despite discussion of flexibility, case management was recommended annually. While appreciating the baseline, he was concerned about the cost and confused about the reference to flexibility. Mr. Vincent-Jones replied that, pursuant to comments, an assessment of the need for case conferencing would be done annually by the program. Guidelines for the assessment would be in the standards. Flexibility was addressed throughout the framework, allowing for various program designs and variations on patient treatment plans.
- Mr. Land asked for OAPP's perspective on working through the process and obtaining sufficient resources by Year 19. Mr. Vincent-Jones noted that the Commission was charged with planning. It was important to work with OAPP so that recommendations were feasible, especially since areas like data management were under their purview.
- Mr. Pérez submitted public comment at the meeting, with a document he distributed. Mr. Vincent-Jones and the Co-Chairs informed him that it was policy that documents could not be distributed at the meetings, but must be part of the prepared meeting packets. The group agreed to include the document on this specific occasion, but informed him that exceptions would not be made in the future.
- Mr. Pérez responded that provider capacity was one key concern. While some providers could transition relatively well, others would need help. OAPP felt staff utilization needed to be addressed, especially regarding staff recruitment/ retention, social workers and RNs. Fiscal health of agencies to pay for increased staff was also a concern. He said that OAPP had estimated an increased cost of $15-18 million for a variation on the model. That would not be affordable in the current financial climate. Resource allocation, solicitation, service delivery negotiation and the program review process would all be based on the assessment.
- OAPP, in general, supported a single source of entry and a uniform client eligibility process, but felt it should be tested on a small scale prior to moving forward. It was important to ensure the model was responsive to client needs, addressed the broad geographic differences of the County and that all model components were critical, e.g., whether a Client Line was needed, and ensuring that service distinctions were not based on acuity.
- Mr. Pérez said OAPP supported a more responsive client level data collection system to track utilization and optimize service delivery. A system that leaned towards a single entry would be valuable even while providing flexibility. Two possible data management systems were reviewed recently at OAPP. Many providers stressed an interface between the County system and those now commonly used by providers.
- OAPP recommended the Commission form a care coordination work group, including OAPP, to consider four questions: 1) refine the proposed model to address more provider feedback; 2) guide the assessment of provider capacity and resource needs; 3) develop a pilot proposal; and 4) inform the selection of a client level data management system to meet the needs of the new care coordination model.
- Mr. Braswell noted that there were three months of discussion about the framework, and expressed concern that OAPP only brought their comments on the last day which gives the Commission little room to include them if it were so inclined. He went on to say that OAPP representatives participated in those meetings, and OAPP's involvement had been and is consistently solicited by the Commission. He continued that provider feedback had been elicited and received in the most extensive and proactive public comment process he had ever been part of. Using a pilot program was discussed,

yet OAPP expressed no concern when it was discussed. Costs were also discussed, but estimates were premature since a framework had not even been approved yet. He felt the focus should remain on the framework as presented.

- Mr. Johnson expressed concern at being asked to move forward with a framework that had not been tested in a pilot or analyzed for cost. He felt the ethical concern that some clients could receive better care than others in a pilot was unrealistic. Everything is tested, e.g., drug trials provide potentially better care to those in the trial.
- Mr. Matthias indicated that APLA supported care coordination, but felt the framework should not move forward without detailed financial cost modeling, as they had requested. They felt a March 2008 RFP process without a pilot program or cost modeling was irresponsible and not in clients' best interests. The framework relied on funding from revision of two service categories, but they felt that would result in an insufficient $2-3 million. Mr. Nolledo also felt fiscal responsibility was key. He offered a motion to refer the matter back to committee for additional information.
- Mr. Land said he seconded the motion to facilitate debate, but supported the framework. APLA's and Common Ground's concerns were addressed for four hours at the SOC meeting, and further hours were spent discussing other comments. While he would like a resource analysis, he understood it was not practical now. Federal priorities were clear, he said, and it was important to move forward to address them.
- Mr. Engeran spoke against the motion. The framework was designed to make changes to a system that all agree needed to change in light of both new laws and experience. It had been an informed and lengthy process. The framework would change the business model. He felt it was important to address client needs in terms of the efficient use of dollars, lack of redundancy and streamlining the process for the reality of the service system today, not a system designed for what was at one point an emergency. He recommended approving the Framework and proceeding to examine it, as outlined, in steps.
- Ms. Jackson asserted that OAPP had not been respectful bringing their comments so late in the process, and questioned why OAPP's proposal only referred to the comments from two non-medical providers, when there were other providers' comments that had been submitted. She was also concerned that RNs and social workers were put on equal footing for intake in the model, but the social worker is not qualified to perform medical intakes. She agreed that a framework was needed first, before one can conduct a financial analysis.
- Ms. Broadus pointed out that OAPP was engaged in the three months of meetings. If they did not provide a cost analysis in that time, she asked how they would be able do so in 30 days, as the motion stipulates. The framework provided the material basis to develop a cost analysis. The Commission could adjust the framework as the process continued. The only question should be whether the framework covered all the material that the Commission wanted studied. If so, move forward. If not, mandate the SOC to return with requested additional material. No hard deadlines were imposed, so study could be as extensive as needed.
- Mr. O'Brien felt most critical comments reflected fear of change. The process would develop specific standards of care, then units of cost would need to be developed for the rate study before there could be RFPs. He felt it was unrealistic to expect RFPs to go out by March 2008 for March 2009 implementation. As it was, it was essential to begin the process.
- Mr. Matthias felt the operating assumption that cost analysis could not be done without the framework was erroneous. He also felt that the rate study should also be done first in order to see how that would affect other care delivery systems and how the reallocation would be done. He also felt the implementation schedule implied erroneously that modeling could not be done.
- Mr. Vincent-Jones said he did not recall a request that OAPP perform modeling, but doubted they could have done it in such a short time anyway. He reiterated that the framework would define what to assess, and had been revised to address written comments from AHF, Common Ground and APLA and others, along with months of painstaking review of verbal comments. SOC originally proposed doing the standards first, followed by the financial assessment. The revised framework presented in the meeting suggested conducting them concurrently. He did not feel that OAPP should do the assessment, but given it was intended to coincide with the standards and in preparation for allocations—it should be a Commission responsibility. The discussion on how to do the financial analysis had not yet occurred.
- Ms. Bailey noted she was a consumer and that she appreciated that the framework addressed her as a whole person.
- Mr. Curtis, APLA, agreed this was a change in the business model. It might be a good change, but any organization would want to know what it was and how much it would cost. He felt the Commission should pause and review disease management programs, managed care programs and home health care programs in the County. APLA spent about $2 million on home health for about 120 clients. It iss an expensive Framework to enact without more financial data.
- Dr. Younai appreciated the comments. She felt people did not always realize what was involved in treating HIV as a chronic disease. The charge of SOC was not to protect agencies, but to ensure clients manage their condition better. The undiagnosed needed to be brought into medical care. Those in medical care needed to receive pertinent preventive and screening tests. She could not see how financial analysis could be done without case loads, agencies and staffing levels. The model has been effective with other diseases. Framework approval would allow the additional work to be done.

MOTION #2A: ***(Younai/Land)*** Call the question ***(Passed unanimously)***.
MOTION #2B: ***(Nolledo/Lamd)*** Refer the Framework back to the SOC Committee and ask OAPP to provide cost estimates and modeling for the various medical care coordination programs within the next 30 days or as soon as practical ***(Failed: 2 Ayes; 24 Opposed; 0 Abstentions)***.

C. Adopting the Medical Care Coordination Framework:

- Mr. Goodman referred to the bottom of page 13. He noted it said "ideally" the medical care manager would triage patients. He felt he would not have successfully entered care that way. While it was important to emphasize medical care, he felt "ideally" set up too strong a program incentive for medical care manager triage. He proposed replacing the second sentence under Intake on page 15 beginning with "ideally" with, "The ideal staff to triage patients as they enter medical care coordination services will be determined by the program."
- Mr. Engeran felt the proposed language was too vague to ensure the level of expertise desired. Ms. Jackson said "ideally" everyone should be triaged by a medical care person, but her physician's office uses the receptionist for primary triage. She recommended strengthening the framework language by deleting "ideally" to ensure triage by medical personnel.
- Mr. Pérez spoke against the proposed alternate language. He felt there should be a range of staffing options, which might not eventually be as prescriptive as a social worker or RN, but would provide minimum standards for staffing patterns. He felt that was necessary to make the model effective countywide.
- Ms. Broadus empathized with Mr. Goodman, but felt it was important not to closely wordsmith the document. She felt that the proposal moved the framework away from the medical care model.
- Dr. Younai said the sentence came from chronic care management literature. Usually someone does a thorough medical triage first. After discussion, it was decided not to restrict triage to the Medical Care Manager, but to allow the Patient Care Manager now doing psychosocial case management to continue to do some level of triage if feasible in conjunction with medical triage. The language was designed to clarify responsibility for those two staff positions only.
- Mr. Vincent-Jones felt most people did not want to engage in wordsmithing. He suggested Mr. Goodman's concern, Mr. Ballesteros' suggestion about prevention case management and Ms. Broadus' comments on the use of "professionalism" all be referred to the SOC to be addressed in standards of care development. Mr. Goodman agreed to withdraw his amendment if there were a commitment by the SOC to address the issues.
- Ms. Watt felt it was important to consider and focus on the key issues. She added that historically costs were often not considered until after the fact. She applauded addressing subjects more comprehensively, but reminded all that the landscape was changing rapidly and funding was not increasing. Anything that improved efficiency was important for the broader picture.
- Ms. Jackson said most things, like the AIDS ward at LAC+USC and Ryan White itself were considered fiscally impossible when proposed. Then people fought to get what they could. She agreed it was important to address the broad picture. She felt, though, that medical case managers needed to be at the top. She noted that AHF has had good experiences with the model in Florida, is very cost effective, and offered to provide cost information on that system. She also felt medical case managers should be co-located at providers. If it was not done now, she felt it would have to be done later. The federal government wanted a medical system and it was important to plan for that now, adjusting as needed regardless of specific providers.

MOTION #2C: ***(Goodman/Lamd)*** Replace the second sentence under Intake on page 15 beginning with "ideally" with, "The ideal staff to triage patients as they enter medical care coordination services will be determined by the program" ***(Withdrawn)***.
MOTION #2D: ***(O'Brien/Broadus)*** Call the question ***(Passed unanimously)***.
MOTION #2#: ***(Broadus/Land)*** Approve the proposed Medical Care Coordination Framework, as presented, with the condition that financial, fiscal, and capacity impact are developed and presented prior to approval of Medical Care Coordination standards of care ***(Passed: 26 Ayes; 0 Opposed; 0 Abstentions)***.

D. Next Steps/Plan of Action:

- Ms. Broadus said that, like in constructing a building, the architect first develops an architectural design. Then the design components are priced out. Likewise, the framework components were Benefits Specialty, Psychosocial Case Management and Medical Case Management.
- Dr. Younai indicated that once the Framework was approved, its components would be costed out appropriately. SOC would address cost analysis once the framework was approved and development of the standards had begun. The Commission would be involved throughout. Only after final approval would allocations be considered for OAPP to implement, although discussions of implementation would begin immediately.

12. PREPARING FOR RYAN WHITE 2010:

A Presentation of the Commission's Proposed Ryan White 2010 Principles:

- Mr. Engeran said the JPP Ryan White Subcommittee had worked six months to develop principles for a new version of Ryan White legislation when it sunsets in 2010. Various principles were proposed and discussed with nearly 50 stakeholders participating.
- Mr. Engeran presented an overview of the principles provided in the policy paper:
  1) HIV disease is a continuum and is chronic.
  2) HIV is unique because it is the only terminal illness, with the possible exceptions of Hepatitis and HPV, which is both chronic and communicable. It is linked with poverty, mental illness and other factors. Preventive care is uniquely able to delay symptoms. Distinctive services continue to be needed to address the nature of the disease.
  3) Ryan White legislation must entail a comprehensive HIV strategy. Funding streams should be better coordinated, e.g., with Medicare, HOPWA, SAMHSA and CDC.
  4) Ryan White as a "last resort" is unrealistic. Instead, it should be retooled as a supplement to other services, like Medicaid, that are not adequate to address the higher costs of HIV care independently.
  5) "Urgency" and "emergency" are not synonymous. Ryan White was originally designed to quickly respond to an emerging disease. A more thoughtful approach should address issues like integration of prevention and care, enhancing access while reducing bureaucracy, increase funding for unmet need and incorporating HIV expertise into existing systems of care.
  6) HIV can be managed, but is not always manageable. The system must be able to react to patient needs.
  7) A united vision leads to a unified response. Jurisdictions must work together rather than at cross-purposes. Proposed common goals were: resources linked to prevalence, eliminating subjective scoring, comparable funding for special needs populations, national parity of care, and universal access.
  8) A national strategy of prevention, services and care is needed. It should include education from children to social marketing, to the medical community and media images.
  9) Financially support quality and efficiency at all levels from national to local. Ryan White could also be used as incentive to encourage regions to address HIV globally with financial rewards to those that enhance efficiency.
  10) Los Angeles County has unique challenges that should be presented in national discussions of regional needs. These challenges range from geography, to demographics, political structure, diversity and the greatest number of uninsured people in a stressed health care system.

B. Discussion:

- Mr. Braswell felt 7 (one vision) and 10 (Los Angeles is unique) contradict. Mr. Engeran felt the national discussion acknowledged differences among regions within the national context. Mr. Braswell felt #6 could be revised to better set up #10. Mr. Vincent-Jones felt the emphasis was on a national approach, but #10 provided defense against those who might want to raise regional concerns to the County's detriment.
- Ms. Broadus said she felt the "unique" qualities in #10 were applicable to other areas. She felt the County also had the largest homeless and incarcerated populations. She asked how to better delineate how the County was unique. She felt the document was well written. She recommended using the principles to begin discussions about national policy. Ms. Granai said each County SPA also had unique challenges that should be acknowledged.
- Ms. DeAugustine noted that California itself suffered due to lack of unity last time. Mr. Engeran agreed that it would be important to reach out to the entire state, possibly even adjoining states. Mr. Kochems felt the principles were designed to get in front of the debate. While larger jurisdictions may not find some principles challenging, the comprehensive national approach would raise discussion in different ways in different areas to work towards more equity across boundaries.
- Mr. Page complimented the work and thanked the Subcommittee for including Hepatitis and reflecting HIV could be managed but was not always manageable.
- Mr. Kochems liked the movement toward a more comprehensive prevention/care response. He suggested adding more bullets that address prevention. He also recommended adding a comprehensive data collection system to #3 and #9.
- Mr. Land was concerned that last time consumers fell out of final discussions; he felt Reauthorization lost consumer participation as it was discussed with legislators and Congress. Mr. Engeran said there were consumers at the table during development and the process required their involvement. Mr. Kochems noted that national consumer organizations like NAPWA could help improve consumer involvement in the future. Mr. Johnson, also a consumer, noted many consumers were intimidated by speaking up at the table with professionals. While there was often no intent to shove them aside, they may feel sidelined. Keeping that in mind could help. Mr. Goodman said he was a NAPWA member and felt good that the Commission was leading even NAPWA.

- Dr. Frye suggested adding to the unique qualities of HIV that it was still stigmatized and, as a sexually transmitted disease, particularly hard to manage. Regarding "urgency" versus "emergency", HIV/AIDS is still emergent. He felt it is important to emphasize that HIV was a continuum since many were confused about the continuance of f AIDS. He also believed that Los Angeles had the highest poverty level in the United States.
- Mr. Kochems said the Subcommittee struggled with terminology. Perhaps "severe HIV disease" would be helpful. Dr. Frye said the CDC was moving toward terms like that. Mr. Braswell felt terminology should follow the CDC's recommendations.
- Ms. Jackson felt the shift away from "AIDS" terminology has resulted in a drop-off of general population interest in HIV/AIDS. She has often encountered people who felt they were two different things. She suggested using "AIDS" universally. Mr. Engeran said the movement seemed to be toward "HIV disease" since those with HIV and with AIDS tended now to be different populations. It was important to continue to address the issue.
- Mr. Hamilton said "a person with HIV" was less stigmatized than "AIDS". HIV was perceived as more life-affirming while "AIDS" was considered terminal. Mr. Orozco also noted there was a difference between how he was perceived when he was considered to have "HIV" rather than "AIDS". He said it was also important to address the needs of farm workers who were often afraid to go to a clinic. Mobile testing units could address these populations. Another issue concerned day laborers who were solicited for sex. Testing in places like Target could assist them.
- Mr. Liso said he had been HIV+ for 19 years and had AIDS. He confirmed "AIDS" carried a stigma and suggested maintaining "HIV/AIDS". He felt management, training, caring and service were key. There should be accountability for providers. He said consumers were the initial engine for Ryan White and should be re-invigorated.
- Ms. Mungo suggested agency cooperation and integrated planning might be better than merging funding, Principle #3. Usually diversified funding was desirable. She suggested a risk assessment before recommending merging funding. Mr. Vincent-Jones responded that the policy didn't suggest merging funding, versus consolidating funding streams into a more uniform strategy.

C. Adopting Ryan White 2010 Principles:

- Mr. Engeran pointed out that the legislation would sunset in 2010. Both sides of the aisle appeared to have the will to make some fundamental changes. This was the time to do so. He felt the principles provided a foundation for developing new legislation. Mr. Kochems made special mention of Wendy Schwartz, who led much of the process but left the Commission when she changed jobs.
- Mr. Kochems noted the motion was revised by adding the section after "as presented" to reflect that it was a working document. Input would be returned to the subcommittee for final revisions and resubmission to the Commission in January.

MOTION #3: Approve the Ryan White 2010 Principles, as presented, with further clarification and elaboration as discussed at the Annual Meeting, with final adoption scheduled for January 2008 ***(Passed: 24 Ayes; 0 Opposed; 0 Abstentions)***.

D. Next Steps/Plan of Action:

- He suggested highlighting specific principles for different groups in order to build dialogue rather than always presenting it as a whole. He suggested a regular process for updating the document. He also recommended working with people who routinely travel to Washington to reiterate the principles in order to build momentum.
- Ms. DeAugustine said many people, especially the young, felt "HIV" was not a big deal. She encouraged more discussion. She reminded everyone that this vote was to accept guiding principles. There would be continuing discussion on other aspects.
- Mr. Land also felt the "AIDS" discussion was important. It might be brought back into the document in a different way. He suggested engaging local consumers in a dialogue as was done for names reporting.
- Mr. Vincent-Jones felt the Southern Manifesto was powerful because it was well documented. He suggested a helpful next step would be to develop more hard documentation.
- Ms. Watt suggested starting collaboration by distributing the document for feedback to EMA/TGA and commensurate prevention body co-chairs once approved. She also suggested developing a one-page handout on the principles to better disseminate the information.
- Mr. Pérez complimented the work. He felt there was good cooperation during the last Reauthorization. He said he had asked Dr. Michelle Roland, OA, to consider a more formal partnership with the County for the next iteration of the Act. He had also reached out to San Francisco. He felt a unified message was expected in Washington and would help.

19. **PUBLIC/COMMISSION COMMENT, NON-AGENDIZED**: There was no public comment.

20. **ANNOUNCEMENTS**:
    - Ms. Granai announced National Coming Out Day. She asked all to remember those who went before and faced discrimination.
    - Mr. Engeran introduced Daniel Rivas, formerly with the PPC, the new AHF Deputy Director, Public Health Division.
    - Mr. Hamilton announced he was no longer with Minority AIDS Project and was unaffiliated. He added that SPA 6 was still looking for representation. He could possibly be moved to the consumer seat and another provider could be located for the provider seat.

21. **ADJOURNMENT**: Mr. Hamilton wished to remember Kevin Spears, who brought him into the Commission about seven years ago. He thanked all who had mentored him. The meeting was adjourned at 2:50 pm in memory of Kevin Spears and those honored by Ms. Granai.
    A. **Roll Call (Present)**: Ballesteros, Bailey, Baumbauer, Bongiorno, Broadus, Braswell, Daar, DeAugustine, Engeran, Goodman, Granai, Hamilton, Johnson, Kochems, Land, Nolledo, O'Brien, Orozco, Page, Palmeros, Sanchez, Varela, Villa, Younai

MOTION AND VOTING SUMMARY		
MOTION #1: Approve the Agenda Order.	***Passed by Consensus***	**MOTION PASSED**
MOTION #2A: ***(Younai/Land)*** Call the question.	***Passed unanimously***	**MOTION PASSED**
MOTION #2B: ***(Nolledo/Land)*** Refer the Framework back to the SOC Committee and ask OAPP to provide cost estimates and modeling for the various medical care coordination programs within the next 30 days or as soon as practical.	***Ayes:*** Daar, Nolledo ***Opposed:*** Ballesteros, Bailey, Baumbauer, Bongiorno, Broadus, Braswell, Chavez, DeAugustine, Engeran, Goodman, Granai, Hamilton, Johnson, Kochems, Land, Long, O'Brien, Orozco, Page, Palmeros, Sanchez, Varela, Villa, Younai ***Abstentions:*** None	**MOTION FAILED** **Ayes**: 2 **Opposed**: 24 **Abstentions**: 0
MOTION #2C: ***(Goodman/Land)*** Replace the second sentence under Intake on page 15 beginning with "ideally" with, "The ideal staff to triage patients as they enter medical care coordination services will be determined by the program."	***Withdrawn***	**WITHDRAWN**
MOTION #2D: ***(O'Brien/Broadus)*** Call the question.	***Passed unanimously***	**MOTION PASSED**
MOTION #2E: ***(Broadus/Land)*** Approve the proposed Medical Care Coordination Framework, as presented, with the condition that financial, fiscal, and capacity impact are developed and presented prior to approval of Medical Care Coordination standards of care.	***Ayes:*** Ballesteros, Bailey, Baumbauer, Bongiorno, Broadus, Braswell, Chavez, Daar, DeAugustine, Engeran, Goodman, Granai, Hamilton, Johnson, Kochems, Land, Long, Nolledo, O'Brien, Orozco, Page, Palmeros, Sanchez, Varela, Villa, Younai ***Opposed:*** None ***Abstentions:*** None	**MOTION PASSED** **Ayes**: 26 **Opposed**: 0 **Abstentions**: 0
MOTION #3: Approve the Ryan White 2010 Principles, as presented, with further clarification and elaboration as discussed at the Annual Meeting, with final adoption scheduled for January 2008.	***Ayes:*** Ballesteros, Bailey, Baumbauer, Bongiorno, Broadus, Braswell, Daar, DeAugustine, Engeran, Goodman, Granai, Hamilton, Johnson, Kochems, Land, Nolledo, O'Brien, Orozco, Page, Palmeros, Sanchez, Varela, Villa, Younai ***Opposed:*** None ***Abstentions:*** None	**MOTION PASSED** **Ayes**: 24 **Opposed**: 0 **Abstentions**: 0